Family Homeostasis and the Physician

DON D. JACKSON, M.D., *Palo Alto*

■ *Physical illness, including psychosomatic disorders, often play an unexpected role in maintaining emotional balances within the family. The outbreak of such disorders, conversely, can be utilized by the physician as a barometer of family emotional difficulties.*

RECENTLY, an English general practitioner published a modest little book[4] in which he noted (and presented in graphic form) that the families he was treating in a small English industrial town tended to have illnesses in clusters. He had devised a system whereby he kept records of each family on a single card, with the individual family members listed vertically and the time, in months, marked off horizontally, so that he could note by glancing at the card not only the usual data of who had what illness when, but that a family tended to have an agglomeration of illnesses in one time period. In general, the illnesses that clustered did not include such complaints as broken legs but were either "psychosomatic," that is, headaches, stomach upsets and the like, or were infectious diseases, some of which he felt were not necessarily highly contagious. He documented that in some of his families an individual could have a cold without the other members catching it. In some of his families, when one person got a cold, some other family members were apt to join him.

The author is director of the Mental Research Institute, Palo Alto, and clinical associate professor of psychiatry, Stanford University School of Medicine, Palo Alto.

Presented before a joint meeting of the Sections on Psychiatry and Neurology and General Practice at the 94th Annual Session of the California Medical Association, San Francisco, March 28 to 31, 1965.

This observation of the supra-individual effect of the family on its members goes along with what has been one of my primary interests for many years, the question of family homeostasis. In 1954, I wrote a paper[2] which was based on my first two and a half years in the private practice of psychiatry in Palo Alto. I had come here from a training center where very sick psychiatric patients were treated largely by intensive individual psychotherapy. With an ambulatory practice in a relatively small town, I discovered that treating an individual patient meant having contact with his family (which I was not used to), and one of my early cases turned out badly:

I was seeing a young housewife for a fairly acute depression, and she seemed to be responding rather well. I had met her husband briefly when I had first seen her in the hospital and had spoken with him a few times over the phone. Unfortunately, it did not dawn on me to invite him in, nor especially did it occur to me to see this couple together. Just when I thought the patient was getting out of the woods, I

began getting phone calls from the husband, usually in the evening, asking about his wife's treatment and expressing concern that she was getting worse. His concern caused me concern, because I thought I must be missing the boat; but it did not occur to me for several weeks that the boat I was missing was his and not hers. The wife was indeed improving, but her husband was beginning to have trouble. One morning, the wife informed me that her husband had lost his job and that she was quite surprised at this since he had the reputation of being a successful, bright young man. I called him and asked him to come in and see me, but he refused, stating that he was too busy looking for work and that his wife was the real problem. It was clear from his tone that he was not feeling very cordial toward me. The following evening, I read of his suicide in the paper. His wife was spending a few days with relatives out of town, and, unwittingly, we all had deserted him.

Since this initial experience, I have had literally hundreds of clear-cut situations involving an upset in one family member caused by a change in the emotional status of another member. Some of these cases I have dealt with personally, some have been discussed with colleagues and others have occurred during the course of supervision of psychiatric residents. However, my observations have not been limited to typical "psychiatric problems." As a member of the Palo Alto Medical Clinic, I had access to medical, and occasionally surgical, cases that the ordinary psychiatrist might not encounter. It became apparent to me that homeostatic imbalance can involve physical illness as well as emotional ones.

The concept of homeostasis stems from Cannon's epoch-making physiological studies, and from the earlier efforts of Claude Bernard with his concepts of *"le milieux interieur."* Homeostasis is not synonymous with static balance. It implies, instead, that a system is in operation and that processes are going on which keep the system relatively stable. Too often the concept of homeostasis is confused with a static notion like balance, but simple balance and imbalance do not convey the subtlety of interdependent, active processes intended by the term homeostasis.

We can make our notion of family homeostasis specific by describing the family as an "error-activated system" which seems to react to inputs that are not in accordance with its baseline or rules. A simple furnace thermostat is a good analogy: Essential to the concept of corrective feedback is the distinction between deviation-counteraction and deviation-amplification (negative and positive feedback, respectively). The usual household thermostat responds to increased heat by shutting off the furnace when the temperature reaches, say, 68 degrees. This is a deviation-counteracting system. However, if increased heat instead *activated* the furnace to produce even more heat, this would be an example of positive feedback and the result would be a deviation-amplifying system which would produce too much heat, large fuel bills, and soon a ruined furnace.

We know there are small (for example, family) and large (for example, nation) human systems that react in deviation-amplifying ways. For example, nation *A* and nation *B* have a naval treaty limiting both to certain numbers of capital ships. Nation *A* gets worried about *B,* so it builds an extra destroyer to patrol *B's* coast. Alarmed and outraged, *B* builds a cruiser to guard against *A's* destroyer. Whereupon *A* retaliates with the launching of a battleship, and on they go to war.

So too there are family wars. If the husband and wife have what we call a symmetrical relationship (that is, one based on the need to prove equality), then each will feel that he has the right to determine the nature of their relationship: If the wife buys a five-dollar pair of hose, the husband will have to get a necktie; if the husband lets the kids stay up late for a television program, the wife will let them stay up to watch the one after that. Obviously in such a relationship situation, ordinary "family work," let alone pleasant interaction, cannot occur; and, as the situation worsens, just as with nations *A* and *B,* the spouses will blame each other until divorce, desertion or disaster is the inevitable outcome.

From this example we can see that if the family is to remain a family unit, negative feedback, or deviation-counteracting mechanisms, must play a large part. The average family absorbs "inputs" from its social, economic, and community environment, as well as from the behavior of individual members and the inevitable changes brought by time; still the family that endures counteracts these deviations and maintains its organization with a facility which makes the household thermostat appear as child's play.

The problem is that this baseline may involve psychiatric symptom manifestation on the part of one family member; and an "error" or deviation" in the form of the patient's improvement may, as I have shown in my first example, lead to strong counteraction from other family members. Thus, the rest of the family may insist that the identified

patient is still "really" sick, even going to great lengths to prove this or make it possible. My experience has convinced me that one does not assume that the identified patient lives in a vacuum; to the contrary, his improvement may result in family resistance, physical or emotional symptoms in other family members, or even the dissolution of the family. While one should not seek to preserve such a homeostatic balance, neither can one ignore its obvious practical implications. For example:

(a) A husband urged his wife into psychotherapy because of her frigidity. After several months of therapy she felt less sexually inhibited, whereupon the husband became impotent.

(b) A young woman with *anorexia nervosa* was persuaded to enter psychotherapy by her husband. Following a period of intense, rather dangerous, acting out, she began to relate more intimately to her husband. The husband's initial pleasure at her response was marred by his developing a duodenal ulcer.[2]

(c) During a family interview the patient's brother, encouraged by his relationship to the therapist, tentatively ventured that his mother might be a little hypocritical in her dealings with the patient. The father, with a liberal sprinkling of alibis for her, agreed with the son and his wife quietly accepted the verdict but with an air of "that's what I get for trying my best." Unfortunately, the therapist had the impression that the mother was accepting the comment and since it was near the end of the session nothing further was done with it.

Early the following morning the mother was taken to the hospital for an emergency cholecystectomy although she had had no previous history of gall bladder distress or of stones. Upon her return home the father was put in hospital for a coronary attack and in the midst of this psychosomatic melee the brother, who had initially introduced the damaging remark, had three automobile accidents, all of a similar nature: He simply crashed into the rear of the car ahead. At this point the family decided that they could no longer afford our expert help and placed the patient in a state hospital.

(d) A young man was sent to the psychiatrist by his wife because of three recent episodes of infidelity. It became apparent during the interview that (1) he had become successful recently after some years of working toward it in dubious battle; (2) his wife had recently had their third child, a boy, and the patient was the third child in his family. The wife had a younger brother who was the favorite in her family and who was referred to as a "juvenile delinquent"; (3) the wife was unbelievably naive or else she was pushing the patient toward his extracurricular activity; (4) the patient did all that one can do and still manage to remain unaware of it, in order to signal to his wife that he was being unfaithful.

The patient was asked to bring his wife to the next visit since his cure lay largely in her hands. This request was made since it was obvious that she felt unimportant and also, in the typical manner of the injured party, felt uninvolved in his sins. Although she came initially with the attitude of "anything to help George get over this nasty business," by the end of the second session she was able to accept the comment that her finger was also in this particular pie. They were seen altogether for only nine sessions with two follow-up visits and made remarkable progress. The brevity of the therapy was partly pecuniary and partly because of the amount of work they did together between sessions.[4]

If the family operates as an error-activated system, then this fact should be observable and testable. During the many years of concentration on the individual, psychiatrists, and psychologists were neither concerned with nor aware of the tremendous impact of family forces. Indeed, until the publication of Richardson's remarkable book, *Patients have Families*,[5] one could learn more about the family from fiction than from a psychiatric textbook. The study of the family has burgeoned since World War II, and this seems to have been stimulated both by the general scientific emphasis on systems (cybernetics, for instance), and by the specific experiences that therapists were having with schizophrenic patients. As long as schizophrenia was considered an organic disorder and a rather hopeless one, the therapist did little in the way of treating schizophrenic patients other than isolate them in large steel and concrete mausoleums euphemistically called hospitals. The experience of psychiatrists during World War II was often that acutely psychotic patients showed remarkable ability to recover quickly, a phenomenon that caused many therapists, on returning to civilian practice, to continue an interest in treating patients with schizophrenia. They quickly realized that there was something unusual about the patient's family, and the early family theories of Lidz, Bowen, Batson, Jackson and others were all based on the study of families of schizophrenic patients. Now there are a number of centers in the United States, including the Mental Research Institute in Palo Alto, where the primary focus of research is on the family.

Evidence that the family is an error-activated system, and that it has specific homeostatic mechanisms, is not limited to the clinical experience of seeing a patient's improvement lead to an upset in another family member; it also is beginning to come from experimental work. For example,

Haley[1] has shown with the aid of a computer that the simple measurement of who talks after whom in a family reveals distinct patterns for each family, and these patterns are not only extraordinarily consistent, but are different in "normal" and "abnormal" families. In a sample of a hundred families (50 normal and 50 abnormal), the abnormal families used far fewer patterns of "who talks after whom," and the difference between the two groups was significant at $p = .00003$. On retests as long as six months to a year later, abnormal families maintained to within a few percentage points exactly the sequences they had established previously, whereas normals varied.

This confirms two clinical hypotheses: (1) that families in general establish a baseline, a set of rules, or something analogous to the setting of the furnace thermostat at a certain desired temperature, and that they maintain this consistency over time regardless of the innumerable assaults which must be made on it both by the environment and the individual members; (2) that families which contain a deviant member (this sample includes families of psychiatric patients, of patients with ulcerative colitis, of underachieving sons, and a wide variety of other symptom bearers) are extremely fixed in their homeostatic patterns and do not "permit" deviation from such patterns.

Thus, the hunches of clinicians have once again turned out to be correct. However, none of us suspected that the family was quite as rigid a system as it appears to be—although most of us who live in a family realize that we can be quite different outside the family than we might be at home. Any of you who have attended a convention may have had cause to marvel at your own and others' behavior away from the supports and constraints of usual surroundings.

Mental Research Institute, 777 Bryant Street, Palo Alto, California (94301).

REFERENCES

1. Haley, Jay: Research on family patterns: An instrument measurement, Family Process, 3:41-65, 1964.

2. Jackson, Don: The question of family homeostasis, Psychiat. Quart. Supp., 31:79-90, Part 1, 1957.

4. Kellner, Robert: Family Ill Health: An Investigation in General Practice, Charles C Thomas, Publisher, Springfield, 1963.

3. Jackson, Don D.: "Family Interaction, Family Homeostasis and Some Implications for Conjoint Family Psychotherapy" in Individual and Familial Dynamics, Grune & Stratton (Jules Masserman, editor), New York, 1959.

5. Richardson, Henry B.: Patients Have Families, The Commonwealth Fund, New York, 1945.